Remarks of Chairman Henry A. Waxman
Subcommittee on Health and the Environment
to the
House Budget Committee
on the President's Budget Proposals

Thank you, Mr. Chairman, for the opportunity to testify this morning on President Clinton's budget proposals. Overall, this is an insightful and courageous proposal. The President has met head on two of our greatest challenges -- improving the economy and reducing the deficit -- and I support him in these efforts.

He has also recognized that a major component of revitalizing the economy and reducing the deficit must be the enactment of comprehensive health care reform. No other President has so clearly made the link between the crisis in our health care system and our national economic problems. I applaud President Clinton's commitment to health care reform, and I look forward to working with him on this issue.

Let me turn now to some comments and concerns that I'd like to express on a number of health and environment programs.

Medicare

The President's proposals include a series of Medicare outlay reductions that would, over the next five years, reduce expenditures by over $53 billion. The magnitude of these reductions, if accomplished without any other health system changes, could significantly increase the cost of services in the private sector. It is my firm belief that further reductions in Medicare outlays should be pursued in the context of containing health costs as a part of health care reform. Savings from publicly financed health programs should be used to support universal coverage for basic health services.

I do want to express my support for the Administration's decision to reject any proposal to link the Medicare Part B premium to income. It is my view that such a policy would undermine the goal of universal, voluntary participation in Part B. It would be unwise to create incentives for higher income beneficiaries to seek coverage for Part B services in the private insurance market. Certainly, one of the strengths of the Medicare program has been the broad base of support it enjoys across all income groups.

I would also like to acknowledge my support for exempting primary care services from across-the-board cuts in physician services. As we move to restructure our health system to emphasize primary and preventive care, we must continue adequate support for the delivery of these services.

At this point I have not had an opportunity to review in detail all the Medicare proposals included in the President's economic message. However, I do think we must carefully consider the magnitude of these cuts, and the impact they are likely to have on Medicare beneficiaries' access to care. Prior reductions of $44 billion in Medicare under the Omnibus Budget Reconciliation Act of 1990 are still being implemented. While there is no evidence of widespread limitations on patient access to doctors and hospitals, I think we must proceed cautiously. It would certainly be counterproductive to make payment cuts that undermine those institutions and practitioners that many beneficiaries rely upon.

I do want to reiterate how critical it is to integrate these short-term budget proposals with plans for comprehensive health reform. While I would expect the Medicare program to continue as a separate program for the elderly and disabled, the interaction between Medicare and the private sector requires careful coordination.

Medicaid

In the Medicaid program, the President proposes $8.7 billion in outlay reductions over the next 5 years. Again, as in the case of the Medicare savings, I believe that whatever responsible savings we can find in the Medicaid program should be applied to the financing of health care reform.

Even in a program as large as Medicaid – projected to cost the Federal government $92 billion in FY 94 – $8.7 billion over 5 years is a large reduction. I do not believe that we can achieve that level of savings without shifting costs to the States, reducing reimbursement to providers, or terminating coverage for beneficiaries.

A few brief comments on the President's proposed changes. The President proposes to reduce enhanced matching rates for certain administrative functions, including inspections of nursing homes, the operation of State fraud control units, and utilization control and quality assurance. CBO estimates this will reduce Federal Medicaid outlays by $1.7 billion over the next

five years.

Your Committee has rejected this proposal three times in the past. I would urge you to do so again. It will not "save" money; it is purely a shift of costs to the States. More importantly, it threatens some extremely important activities at the State level. For example, if Federal matching funds for nursing home inspections are reduced, then States like California -- which is in the third year of the most severe economic downturn since the 1930's -- will not make up the shortfall with their own funds. Instead, they will reduce the number of inspections, leaving residents in substandard facilities unprotected. Similarly, if Federal matching funds for fraud control units are reduced, States will not replace the lost Federal dollars. This will result in fewer investigations, fewer prosecutions, and a reduced pressure on fraudulent and abusive providers.

In short, these matching rate reductions send the wrong message and should be rejected.

The President has also proposed to remove the prohibition against the use of drug formularies by State Medicaid programs. CBO estimates this will reduce Federal outlays by $225 million over the next 5 years.

As you will remember, in 1990 you instructed my Committee to legislate changes in Medicaid that would achieve $1.9 billion in savings through reforms in the purchase of prescription drugs. We complied -- after a memorably contentious debate as to how to make these changes. What emerged in the 1990 budget reconciliation bill was an agreement between the Federal government and the drug industry: we will give you access to a national Medicaid market for all your products, and you will give us (and the States) rebates on each of your products. Just last year, we extended this basic agreement to the Veterans Administration, the Department of Defense, and Public Health Service-funded clinics.

The President's proposal would, in effect, reopen this agreement by allowing each State to pick and choose the drugs it will offer under its Medicaid program through the use of formularies. This potentially eliminates the national Medicaid market and may destabilize the 1990 agreement. While the use of formularies can potentially generate savings, if we are to go this route it is essential that we prevent States from using formularies that deny beneficiaries access to high-cost but medically necessary drugs. While I agree that Medicaid is still paying too much for many drugs, I hope that your Committee and the Administration consider other approaches to savings in this area.

Earlier this week the Washington Post described how the State of New Hampshire and the Bush Administration had negotiated a series of deals under which the State collected over $400 million in extra Federal matching funds during 1991 and 1992. According to the Post, State officials said that "only a small amount of the windfall went to expanding services for low-income families, disabled, and elderly beneficiaries; instead, the funds were used to balance the State's budget without any State tax increases. Evidently, this is what the Bush Administration thought of as "flexibility."

Let me be very clear on this. First, if what the Post reports is accurate, it represents a completely unacceptable use of Federal Medicaid dollars. I am confident that the Clinton Administration will not tolerate the use of Federal Medicaid dollars to fund State judicial systems, highway programs, or anything other than the provision of covered health and long-term care services to eligible beneficiaries.

FDA

The budget also includes more than $1.0 billion in user fees over four years to be paid by drug and medical device companies that receive safety and efficacy certifications from the Food and Drug Administration. I would like to make two points with respect to these fees.

First, I assume that these fees are above and beyond the drug user fees that were enacted last Congress as part of the Prescription Drug User Fee Act of 1992 (P.L. 102-571). That law will raise approximately $325 million in user fees to be paid by drug companies. Those fees will be dedicated to increasing resources for the drug approval process and to significantly speeding up the approval of drugs designed to treat serious and life-threatening diseases such as cancer and AIDS. The Food and Drug Administration has projected that within five years, as a result of the Act, it will be able to reach decisions on approving these drugs in six months -- one-half that time required in recent years. It is critical to the public health that the approval of important drugs not be delayed because of inadequate resources at the agency. Full implementation of the Prescription Drug User Fee Act of 1992 is the best means of promoting that important goal.

Second, in the past, many of us have strongly opposed proposals to charge user fees to regulated industries. Last year, John Dingell and I worked with the Administration, the drug industry, the Ways and Means and Appropriations committees, and the relevant committees in the Senate to craft a user fee bill that is dedicated to improving the functioning of the regulatory process, not reducing the deficit. This was a carefully crafted compromise that could

be used to improve other programs at the FDA, and could be used as a model for other agencies. The drug industry was wary of entering into negotiations to establish a workable user fee program, and many members were extremely reluctant to support the bill, because of they feared that the user fees would ultimately go towards deficit reduction rather than the promised improvements at FDA.

If, only a few months after negotiating this package supported by all parties, we use the concept of user fees for deficit reduction, I fear we have will closed the door to future cooperation on the applying user fees to improve the functioning of federal agencies. Therefore, I urge the Committee to delete from the budget any user fees that are inconsistent with the Prescription Drug User Fee Act.

Environment

I am very pleased to see that the Clinton Administration has proposed substantial new federal funding to support the efforts of states and localities to meet the contamination standards of the Safe Drinking Water Act. Such funding is desperately needed to help water suppliers provide safe water as the Act requires. I also commend the Clinton Administration for selecting a revenue-producing mechanism, the energy tax, that will serve to promote energy conservation and reduce pollution.

I am concerned, however, that some components of the Administration's economic stimulus proposal could unintentionally increase public and worker exposure to lead. Within the last year, the National Institute for Occupational Safety and Health (NIOSH) and several states issued "hazard alerts" reporting extensive lead poisoning during construction projects such as bridge renovation. Increasing federal investment in these projects in the stimulus package could increase worker lead poisoning and public exposure unless proper precautions are adopted. Congress enacted such precautionary measures last year in the Lead-Based Paint Hazard Reduction Act (Title X of P.L. 102-550). The Committee recommends that these measures be implemented and funded as part of any effort to stimulate infrastructure renovation.

AIDS

Turning to AIDS issues, while the indications are that the budget will include additions in Ryan White funding, as well as incremental increases in research and prevention

funds, the epidemic is building up such speed that more funding will be needed sooner. Postponing these expenditures will only compound the problems, leading to more illness and more ultimate costs.

Tuberculosis

Although the President's budget does not address public health programs in great detail, I would like to state for the record that I believe that we need to make an immediate investment in tuberculosis research, prevention, and control. Any short-changing of these activities at this point would certainly result in very serious problems in the future.

We have the opportunity to keep a major outbreak from turning into a major epidemic, and the Centers for Disease Control has laid out a Multi-Drug Resistant (MDR) TB control plan with first year costs of $525 million. While this is a major investment, it is certainly cheaper than the spread of MDR TB hospitalizations and deaths that will otherwise result.

I know we face a difficult task of reconciling these important needs with the obvious budget constraints, but I look forward to working with the Committee and the President to do all we can to ensure the health of the American people.